111 A. ADMINISTRATORS COMPENSATION:

The reasonable cost of full-time nonowner administrators may be included as an allowable cost so long as it does not exceed the applicable compensation limit for an administrator.

Fringe benefits routinely provided to all employees and the administrator will not be considered a part of compensation.

Reasonableness of compensation for an administrator will be based on total licensed beds (all levels) in accordance with the following schedule. The amount attributable to each level of care will be determined utilizing the step-down method of cost allocation.

BED SIZE	MAXIMUM COMPENSATION
0-50	$41,400
51-99	46,800
100-149	52,400
150-199	62,600
200+	64,000

These compensation maximums shall be increased on July 1 of each year by the Inflation Factor index for wages and salaries (Data Resources, Inc.).

112. INTERIM RATE FOR NEW FACILITIES

For facilities newly constructed and open for business within twelve months prior to date of entry into the Program, and for other facilities initially entering the Program, the initial payment shall be based on a temporary rate. The temporary rate shall be computed using a sum of a nursing services cost component, the applicable all other cost per diem upper limit, and other applicable allowances used in the current rate year. The nursing services cost component shall consist of the applicable nursing services cost per case mix unit upper limit multiplied by the case mix weight for the facility as established by the most recent case mix assessment until the facility is assessed, the case mix utilized to the temporary interim shall be statewide average for all facilities during the most recent assessment quarter. The upper limits used shall depend on the facility's urban or rural classifi- cation. The rate is not subject to the occupancy factors. Hospital-based nursing facilities shall receive a temporary rate using the applicable hospital-based upper limits. The temporary rate shall be recalculated quarterly.

Until such time as a rate has been determined on the basis of an audited cost report containing twelve months of actual data in the fiscal year, payments shall be subject to settlement based on audited cost data.

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An ancillary settlement shall be made on the basis of an audited cost report based on the facility's fiscal year.

At the end of the first full facility fiscal year, the following procedure shall be utilized to yield a modified occupancy rate for setting the prospective rate for the next fiscal year. This modified occupancy rate is to be derived from the average occupancy rate for the facility's last quarter of the first full facility fiscal year and averaging this rate with 90% occupancy in the facility. The derived rate shall be applied to the total allowable costs of the second full facility fiscal year in order to determine the per diem rate to be allowed for that fiscal year. If the referenced last quarter's occupancy rate is above 90%, the general occupancy rate shall be imposed for subsequent rate setting periods.

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114. PAYMENT OF SPECIAL PROGRAM CLASSES

A. STATE DEFINED DUAL LICENSED ACUTE CARE BEDS. Pursuant to legislation enacted by the 1986 General Assembly, a licensed acute care hospital may obtain a dual license for twenty-five (25) licensed acute care beds or 10% of the hospital's total licensed acute care bed capacity, whichever is greater, but not to exceed 40% of the hospital's total licensed acute care bed capacity, to provide nursing facility care in such beds.

The Program shall reimburse acute care hospitals for nursing facility services provided to patients placed in dual licensed beds. The reimbursement rate for routine services for dual licensed beds shall be the appropriate urban or rural upper limits for hospital-based nursing facilities taking into account the facility's average case mix weight, plus any additional rate allowances added on to other nursing facilities' rates, except that dual licensed beds are not eligible for the rate adjustments provided for in sections 110 and 111 of this manual.

B. FEDERALLY DEFINED SWING BEDS. Federally defined swing beds are reimbursed by the Kentucky Medical Assistance Program at the weighted average payment rate for routine services for the prior calendar year for all nursing facilities in the state.

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C. ANCILLARY SERVICES FOR DUAL LICENSED AND SWING BEDS. Payments for reimbursable ancillary services provided to nursing facility patients in dual licensed or swing beds are based on a percent of charges with a settlement to the lower of actual cost or charges at the end of the facility's fiscal year. Ancillary services covered shall be the same ancillary services as are covered in the regular nursing facility setting.

Swing Bed facilities shall be required to file Schedules A, D-5 and E as well as the ancillary portion of Schedule F of the Nursing Facility Cost Report to the Long-Term Care Reimbursement Branch. Dual licensed bed facilities shall be required to file Schedules A, D-5, and E as well as the ancillary portion of Schedule F of the Nursing Facility Cost Report, as well as Supplemental Medicaid Schedules KMAP-2 and KMAP-3 of the Hospital Program.

D. HEAD INJURY UNITS. Facilities which meet the criteria for a Head Injury Unit shall be reimbursed their usual and customary charges up to an all-inclusive rate of $360.00 per diem (excluding drugs which shall be reimbursed through the pharmacy program). Such units shall be excluded from the nursing facility arrays.

E. CARE NEEDS ASSOCIATED WITH INFECTIOUS DISEASES.

Effective October 1, 1990, a special access and treatment fee shall be paid to Nursing Facilities caring for residents with care needs associated with highly infectious or communicable diseases with limited treatment potential, such as:

Hepatitis B

Methicillin - Resistant Staphylococcus Aureus (MRSA)

Acquired Immune Deficiency Syndrome - AIDS

Human Immunodeficiency Virus (HIV) Positive

The special access and treatment fee of $10.00 per diem shall be added to the CMAR per diem rate for each resident determined to qualify by the peer review organization.

Ancillary services for these residents shall be paid in accordance with policies outlined in the General Policies and Guidelines.

F. VENTILATOR FACILITIES. Ventilator facilities are those facilities that had a bona fide Ventilator Therapy Program with at least ten (10) residents being served prior to July 1, 1985. Services to ventilator residents in these facilities shall be reimbursed under an all inclusive rate (excluding drugs which shall be reimbursed through the pharmacy program).

115. PAYMENT FOR ANCILLARY SERVICES

The reasonable, allowable, direct cost of ancillary services as defined provided as a part of total care shall be compensated through the Program on a reimbursable cost basis as an addition to the prospective rate and shall be subject to a year-end audit, retroactive adjustment and final settlement.

Each provider shall request a percentage factor tailored to its own individual cost/charge ratios for ancillary services. These ratios shall be limited to 100 percent and each request shall be analyzed by Department staff to determine appropriateness of the requested percentage factor. Reimbursable ancillary costs shall be determined based on the ratio of Program charges to total charges applied to direct departmental costs.

A retroactive settlement between actual direct allowable costs and actual payment made by the Program shall be made at the end of the accounting period based on the facility's Annual Cost Report.

Indirect ancillary cost shall be included in routine cost and reimbursed through the prospective rate.

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116. RETROACTIVE ADJUSTMENT FOR ROUTINE SERVICES

A. A retroactive adjustment may be made for routine services in the following circumstances:

1. If incorrect payments have been made due to computational errors, i.e., mathematical errors, discovered in the cost basis or establishment of the prospective rate. Omission of cost data does not constitute a computational error.

2. If a determination is made by the Program of misrepresentation on the part of the provider.

3. If a facility is sold and the funded depreciation account is not transferred to the purchaser.

4. If the prospective rate has been set based on an unaudited cost report and the prospective rate is adjusted based on a desk review or field audit. The appropriate cost settlement shall be made to adjust the unaudited prospective payment amounts to the correct audited prospective payment amounts.

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If adjustments are necessary, any amounts owed the provider shall be paid by the Program. Any amounts owed the Program shall be paid in cash or recouped by a reduction of the payment rate during the remainder of the reporting year.

B. BANKRUPTCY OR INSOLVENCY OF PROVIDER. If, on the basis of reliable evidence, the Program has a valid basis for believing that, with respect to a provider, proceedings have been or may shortly be instituted in a State or Federal court for purposes of determining whether such facility is insolvent or bankrupt under an appropriate State or Federal law, any payments to the provider shall be adjusted by the Program, notwithstanding any other reimbursement principle or Program instruction regarding the timing or manner of such adjustments, to a level necessary to insure that no overpayment to the provider is made. This section shall be applicable only to ancillary services.

117. RETROACTIVE ADJUSTMENT FOR ANCILLARY SERVICES

A. Actual cost reimbursable to a provider cannot be determined until the cost reports are filed and costs are verified. Therefore, a retroactive adjustment shall be made at the end of the reporting period to bring the interim payments made to the provider during the period into agreement with the reimbursable amount payable to the provider for the ancillary services rendered to Program beneficiaries during that period.

B. In order to reimburse the provider as quickly as possible a partial retroactive adjustment may be made when the cost report is received. For this purpose, the costs shall be accepted as reported - unless there are obvious errors or inconsistencies - subject to later audit. When an audit is made and the final liability of the Program is determined, a final adjustment shall be made.

C. To determine the retroactive adjustment, the amount of the provider's total allowable ancillary cost apportioned to the Program for the reporting year is computed. This is the total amount of the reimbursement the provider is due to receive from the Program

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